| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155614 | A. BUILDING 01<br>B. WING | 12/10/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN HILLS OF NEW ALBANY | 326 COUNTRY CLUB DRIVE<br>NEW ALBANY, IN 47150 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K0000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 12/10/12<br><br>Facility Number: 000321<br>Provider Number: 155614<br>AIM Number: 100286130<br><br>Surveyor: Mark Bugni, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Lincoln Hills of New Albany was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be Type II (111) construction and fully sprinklered except the C Hall entrance foyer. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident | K0000 | Preparation and execution of thisresponse and plan of correctiondoes not constitute an admissionor agreement by the provider ofthe truth of the facts alleged orconclusions set forth in thestatement of deficiencies. Theplan of correction is preparedand/or executed solely because itis required by the provisions offederal and state law. Forpurpose of any allegation that thefacility is not in substantialcompliance with federalrequirements of participation, theresponse and plan of correctionconstitutes Lincoln Hills of NewAlbany's allegation of compliancein accordance with Section 7305in the State Operations Manual | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | sleeping rooms. The facility has a capacity of 152 and had a census of 121 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered except the C Hall entrance foyer. The facility has twenty foot by twelve foot wooden storage garage and a ten foot by twelve foot wooden storage shed which were not sprinklered.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/13/12.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |

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| K0029 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br>Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire door was in accordance with NFPA 80 for 1 of 19 hazardous areas. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient | K0029 | In compliance with NFPA 101, 19.3.2.1, the facility does have an approved automatic fire extinguishing system and areas are separated from other spaces by smoke resisting partitions and doors. The kitchen vertical rolling fire door was inspected by FESCO/FASCO on 12/18/12 and found to be working properly at this time. This will be inspected annually to ensure that it is functioning properly.Maintenance Director will monitor dates of inspection during annual Preventative Maintenance checks.Administrator will be responsible for routine monitoring and compliance. | 01/07/2013 |

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| | practice could affect 73 of the 121 residents using the main dining room, located adjacent to the kitchen.<br><br>Findings include:<br><br>Based on interview on 12/10/12 and Fire Safety record review at 8:45 a.m. with the maintenance supervisor, it was acknowledged there was no documentation of an annual inspection or test to check for proper operation and full closure of the kitchen vertical rolling fire door. Based on observation on 12/10/12 at 10:30 a.m. with the maintenance supervisor, the rolling fire door protecting the opening from the kitchen to the main dining room lacked an attached inspection tag. The main dining room was open to the corridor. The lack of an annual rolling fire door inspection was acknowledged by the administrator at the 1:15 p.m. exit conference on 12/10/12.<br><br>3.1-19(b) | | | |

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| K0056 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br>Based on observation and interview, the facility failed to ensure 1 of 10 corridors were completely sprinklered. This deficient practice affects 24 residents who reside on the C Hall.<br><br>Findings include:<br><br>Based on observation on 12/10/12 at 12:20 p.m. with the maintenance supervisor, the C Hall corridor entrance foyer, which measured four feet by eight feet, was not provided with sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator the the 1:15 p.m. exit conference on 12/10/12.<br><br>3.1-19(b) | K0056 | In accordance with NFPA 101, 19.3.5, the facility does ensure that the automatic sprinkler system provides complete coverage for all portions of the building. Brown Sprinkler has been contracted to install a pendant sprinkler in the C Hall corridor entrance foyer. Administrator will be responsible for routine monitoring and compliance. | 01/07/2013 |

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| | 3.1-19(ff) | | | |